

108TH CONGRESS
1ST SESSION

H. R. 2402

To expand the number of individuals and families with health insurance coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 10, 2003

Ms. KAPTUR (for herself, Mr. LATOURETTE, Mr. CLAY, Mr. MORAN of Virginia, Mrs. CHRISTENSEN, and Mr. DAVIS of Illinois) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To expand the number of individuals and families with health insurance coverage, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Coverage, Affordability, Responsibility, and Eq-
6 uity Act of 2003” or the “HealthCARE Act of 2003”.

7 (b) TABLE OF CONTENTS.—The table of contents of
8 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—INCREASING HEALTH CARE COVERAGE

Subtitle A—Medicaid and SCHIP

Sec. 101. State option to offer medicaid coverage based on need.

Sec. 102. State option to provide coverage of children under SCHIP in excess of the State's allotment.

Subtitle B—Refundable Tax Credit for Health Insurance Costs of Low-Income Individuals and Families

Sec. 111. Credit for health insurance costs of certain low-income individuals.

Sec. 112. Advance payment of credit for health insurance costs of eligible low-income individuals.

TITLE II—IMPROVING ACCESS TO HEALTH PLANS

Sec. 201. Definitions.

Sec. 202. Establishment of health insurance purchasing pools.

Sec. 203. Purchasing pools.

Sec. 204. Purchasing pool operators.

Sec. 205. Contracts with participating insurers.

Sec. 206. Options for health benefits coverage.

Sec. 207. Enrollment process for eligible individuals.

Sec. 208. Plan premiums.

Sec. 209. Enrollee premium share.

Sec. 210. Payments to purchasing pool operators and payments to participating insurers.

Sec. 211. State-based reinsurance programs.

Sec. 212. Coverage under individual health insurance.

Sec. 213. Use of premium subsidies to unify family coverage with members enrolled in medicaid and SCHIP.

Sec. 214. Coverage through employer-sponsored health insurance.

Sec. 215. Participation by small employers.

Sec. 216. Report.

Sec. 217. Authorization of appropriations.

TITLE III—NATIONAL ADVISORY COMMISSION ON EXPANDED ACCESS TO HEALTH CARE

Sec. 301. National Advisory Commission on Expanded Access to Health Care.

Sec. 302. Congressional action.

TITLE IV—STATE WAIVERS

Sec. 401. State waivers.

1 **TITLE I—INCREASING HEALTH**
2 **CARE COVERAGE**

3 **Subtitle A—Medicaid and SCHIP**

4 **SEC. 101. STATE OPTION TO OFFER MEDICAID COVERAGE**
5 **BASED ON NEED.**

6 (a) STATE OPTION.—Section 1902(a)(10)(A)(ii) of
7 the Social Security Act (42 U.S.C. 1396a) is amended—

8 (1) by striking “or” at the end of subclause
9 (XVII);

10 (2) by adding “or” at the end of subclause
11 (XVIII); and

12 (3) by adding at the end the following:

13 “(XIX) who are not otherwise el-
14 igible for medical assistance under
15 this title and whose income does not
16 exceed such income level as the State
17 may establish, expressed as a percent-
18 age (not to exceed 100) of the income
19 official poverty line (as defined by the
20 Office of Management and Budget,
21 and revised annually in accordance
22 with section 673(2) of the Omnibus
23 Budget Reconciliation Act of 1981)
24 applicable to a family of the size in-
25 volved;”.

1 (b) INCREASED FMAP.—Section 1905 of the Social
2 Security Act (42 U.S.C. 1396d) is amended—

3 (1) in the first sentence of subsection (b)—

4 (A) by striking “and (4)” and inserting
5 “(4)”; and

6 (B) by inserting before the period the fol-
7 lowing: “, and (5) in the case of a State that
8 meets the conditions described in paragraph (1)
9 of subsection (x), the Federal medical assist-
10 ance percentage shall be equal to the need-
11 based enhanced FMAP described in paragraph
12 (2) of subsection (x)”; and

13 (2) by adding at the end the following:

14 “(x)(1) For purposes of clause (5) of the first sen-
15 tence of subsection (b), the conditions described in this
16 subsection are the following:

17 “(A) The State provides medical assistance to
18 individuals described in subsection
19 (a)(10)(A)(ii)(XIX).

20 “(B) The State uses streamlined enrollment
21 and outreach measures to all individuals described in
22 subparagraph (A) including—

23 “(i) the same application and retention
24 procedures (such as 1-page enrollment forms
25 and enrollment by mail) used by the majority of

1 State programs under title XXI during the pre-
2 ceding year; and

3 “(ii) outreach efforts proportional in scope
4 and reasonably expected effectiveness to those
5 employed by the State during a comparable
6 stage of implementation of the State’s program
7 under title XXI.

8 “(C) The State applies eligibility standards and
9 methodologies under this title with respect to indi-
10 viduals residing in the State who have not attained
11 age 65 that are not more restrictive (as determined
12 under section 1902(a)(10)(C)(i)(III)) than the
13 standards and methodologies that applied under this
14 title with respect to such individuals as of July 1,
15 2003.

16 “(2)(A) For purposes of clause (5) of the first sen-
17 tence of subsection (b), the need-based enhanced FMAP
18 for a State for a fiscal year, is equal to the Federal med-
19 ical assistance percentage (as defined in the first sentence
20 of subsection (b)) for the State increased, subject to sub-
21 paragraph (B), by such percentage increase as would com-
22 pensate all States for the additional expenditures that
23 would be incurred by all States if the States were to pro-
24 vide medical assistance to all individuals whose income
25 does not exceed 100 percent of the income official poverty

1 line (as defined by the Office of Management and Budget,
 2 and revised annually in accordance with section 673(2) of
 3 the Omnibus Budget Reconciliation Act of 1981) applica-
 4 ble to a family of the size involved and who are eligible
 5 for such assistance only on the basis of section
 6 1902(a)(10)(A)(ii)(XIX).

7 “(B) In the case of a State that provides medical as-
 8 sistance to individuals described in section
 9 1902(a)(10)(A)(ii)(XIX) but limits such assistance to in-
 10 dividuals with income at or below a percentage of the in-
 11 come official poverty line (as defined by the Office of Man-
 12 agement and Budget, and revised annually in accordance
 13 with section 673(2) of the Omnibus Budget Reconciliation
 14 Act of 1981) applicable to a family of the size involved
 15 that is less than 100, the Secretary shall reduce the need-
 16 based enhanced FMAP otherwise determined for the State
 17 under subparagraph (A) by a proportion based on the na-
 18 tional income distribution of all individuals in all States
 19 who are (regardless of whether such individuals are en-
 20 rolled under this title) eligible for medical assistance only
 21 on the basis of section 1902(a)(10)(A)(ii)(XIX).”.

22 (c) CONFORMING AMENDMENTS.—Section 1905(a) of
 23 the Social Security Act (42 U.S.C. 1396d(a)) is amended
 24 in the matter preceding paragraph (1)—

25 (1) by striking “or” at the end of clause (xii);

1 (2) by adding “or” at the end of clause (xiii);

2 and

3 (3) by inserting after clause (xiii) the following:

4 “(xiv) individuals who are eligible for medical
5 assistance on the basis of section
6 1902(a)(10)(A)(ii)(XIX);”.

7 (d) EFFECTIVE DATE.—The amendments made by
8 this section take effect on October 1, 2004, and apply to
9 medical assistance provided on or after that date, without
10 regard to whether final regulations to carry out such
11 amendments have been promulgated by such date.

12 **SEC. 102. STATE OPTION TO PROVIDE COVERAGE OF CHIL-**
13 **DREN UNDER SCHIP IN EXCESS OF THE**
14 **STATE’S ALLOTMENT.**

15 (a) IN GENERAL.—Title XXI of the Social Security
16 Act (42 U.S.C. 1397aa et seq.) is amended by adding at
17 the end the following:

18 **“SEC. 2111. STATE OPTION TO PROVIDE COVERAGE OF**
19 **CHILDREN IN EXCESS OF THE STATE’S AL-**
20 **LOTMENT.**

21 “(a) STATE OPTION.—In the case of a State that
22 meets the condition described in subsection (b), the fol-
23 lowing shall apply:

24 “(1) Notwithstanding section 2105 and without
25 regard to the State’s allotment under section 2104,

1 the Secretary shall pay the State an amount for
2 each quarter equal to the enhanced FMAP of ex-
3 penditures incurred in the quarter that are described
4 in section 2105(a)(1).

5 “(2) The Secretary shall reduce the State’s al-
6 lotment under section 2104, for the first fiscal year
7 for which the State amendment described in sub-
8 section (b) applies, and for each fiscal year there-
9 after, by an amount equal to the amount that the
10 Secretary determines the State would have expended
11 to provide child health assistance to targeted low-in-
12 come children during that fiscal year if that State
13 had not elected the State option to provide such as-
14 sistance in accordance with this section.

15 “(3) Subsections (f) and (g) of section 2104
16 shall not apply to the State’s reduced allotment
17 (after the application of paragraph (2)).

18 “(b) CONDITION DESCRIBED.—For purposes of sub-
19 section (a), the condition described in this subsection is
20 that the State has made an irrevocable election, through
21 a plan amendment, to provide child health assistance to
22 all targeted low-income children residing in the State
23 (without regard to date of application for assistance) and
24 to cover health services listed in the State plan whenever
25 medically necessary.”.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 this section takes effect on October 1, 2004, and applies
 3 to child health assistance provided on or after that date,
 4 without regard to whether final regulations to carry out
 5 such amendment have been promulgated by such date.

6 **Subtitle B—Refundable Tax Credit**
 7 **for Health Insurance Costs of**
 8 **Low-Income Individuals and**
 9 **Families**

10 **SEC. 111. CREDIT FOR HEALTH INSURANCE COSTS OF CER-**
 11 **TAIN LOW-INCOME INDIVIDUALS.**

12 (a) IN GENERAL.—Subpart C of part IV of sub-
 13 chapter A of chapter 1 of the Internal Revenue Code of
 14 1986 (relating to refundable credits) is amended by redes-
 15 ignating section 36 as section 37 and inserting after sec-
 16 tion 35 the following new section:

17 **“SEC. 36. HEALTH INSURANCE COSTS OF ELIGIBLE LOW-IN-**
 18 **COME INDIVIDUALS.**

19 “(a) IN GENERAL.—In the case of an individual,
 20 there shall be allowed as a credit against the tax imposed
 21 by this subtitle for the taxable year an amount equal to
 22 the applicable percentage of the amount paid by the tax-
 23 payer (or on behalf of the taxpayer) for coverage of the
 24 taxpayer or qualifying family members under qualified

1 health insurance for eligible coverage months beginning in
2 such taxable year.

3 “(b) APPLICABLE PERCENTAGE.—For purposes of
4 this section—

5 “(1) IN GENERAL.—Subject to paragraph (2),
6 the term ‘applicable percentage’ means the standard
7 Government contribution (determined for full-time
8 Federal employees enrolling in coverage for which
9 such contribution is not limited by section
10 8906(b)(1) of title 5, United States Code) for an
11 employee enrolled in a health benefits plan under
12 chapter 89 of title 5, United States Code, for the
13 calendar year in which the taxable year begins, ex-
14 pressed as a percentage of the total premium for
15 such plan.

16 “(2) INCREASED PERCENTAGE FOR CERTAIN
17 TAXPAYERS.—

18 “(A) IN GENERAL.—In the case of a tax-
19 payer whose adjusted gross income for the pre-
20 ceding taxable year does not exceed 150 percent
21 of the poverty level, the applicable percentage
22 determined under paragraph (1) shall be in-
23 creased by such percentage points as the Sec-
24 retary determines will fully compensate such an
25 individual for the individual’s limited pur-

1 chasing power in comparison to individuals
2 whose adjusted gross income equals the average
3 adjusted gross income for all Federal employ-
4 ees, to the extent that the amount of the result-
5 ing increase in the credit amount for all such
6 eligible low-income individuals for the taxable
7 year is not reasonably expected to exceed the 5
8 percentage point dollar amount for that year, as
9 determined under subparagraph (B).

10 “(B) DETERMINATION OF 5 PERCENTAGE
11 POINT DOLLAR AMOUNT.—For purposes of sub-
12 paragraph (A), the 5 percentage point dollar
13 amount for any taxable year is the product of—

14 “(i) the total number of individuals
15 receiving credits under this section for
16 such year; and

17 “(ii) the amount equal to 5 percent of
18 the average health insurance premium
19 amount to which such credits are applied.

20 “(C) RULE OF CONSTRUCTION.—Nothing
21 in this paragraph shall be construed to prevent
22 the Secretary from establishing more than 1
23 level of supplemental assistance that provides
24 greater assistance to individuals with lower in-
25 come, determined as a percentage of poverty.

1 “(3) APPLICATION OF FEHBP COVERAGE CAT-
2 EGORIES TO DETERMINATION OF CREDIT.—The per-
3 centages described in paragraphs (1) and (2) shall
4 be applied to a taxpayer consistent with the coverage
5 categories (such as self or family coverage) applied
6 with respect to a health benefits plan under chapter
7 89 of title 5, United States Code.

8 “(c) MAXIMUM PREMIUM AMOUNT.—The amount
9 paid for qualified health insurance taken into account
10 under subsection (a) for any taxable year shall not exceed
11 an amount equal to the capped premium established for
12 the applicable State under section 204(c)(10) of the
13 Health Coverage, Affordability, Responsibility, and Equity
14 Act of 2003 for the calendar year in which the such tax-
15 able year begins.

16 “(d) ELIGIBLE COVERAGE MONTH.—For purposes of
17 this section—

18 “(1) IN GENERAL.—The term ‘eligible coverage
19 month’ means any month if during such month the
20 taxpayer or a qualifying family member—

21 “(A) is an eligible low-income individual;

22 “(B) is covered by qualified health insur-
23 ance, the premium for which is paid by the tax-
24 payer (or on behalf of the taxpayer);

1 “(C) does not have other specified cov-
2 erage; and

3 “(D) is not imprisoned under Federal,
4 State, or local authority.

5 “(2) JOINT RETURNS.—In the case of a joint
6 return, the requirement of paragraph (1)(A) shall be
7 treated as met with respect to any month if at least
8 1 spouse satisfies such requirement.

9 “(e) ELIGIBLE LOW-INCOME INDIVIDUAL.—For pur-
10 poses of this section—

11 “(1) IN GENERAL.—The term ‘eligible low-in-
12 come individual’ means an individual—

13 “(A) who has not attained age 65;

14 “(B) whose adjusted gross income does not
15 exceed 200 percent of the poverty level;

16 “(C) who is ineligible for the medicaid pro-
17 gram or the State children’s health insurance
18 program under title XIX or XXI of the Social
19 Security Act (other than under section 1928 of
20 such Act);

21 “(D) who has limited access to health in-
22 surance coverage through the employer of the
23 individual or a member of the individual’s fam-
24 ily (either because the employer does not offer
25 such coverage to the individual or because the

1 employee contribution for such coverage would
2 exceed an amount equal to 5 percent of the
3 household income of such individual, as deter-
4 mined in accordance with paragraph (2));

5 “(E) who applies for a credit under this
6 section not later than 60 days after receiving
7 notice of potential eligibility for such credit,
8 under procedures established by the Secretary;
9 and

10 “(F) who resides in a State where the eli-
11 gibility standards and methodologies applied
12 under the medicaid and State children’s health
13 insurance programs with respect to individuals
14 residing in the State who have not attained age
15 65 are not more restrictive (as determined
16 under section 1902(a)(10)(C)(i)(III) of the So-
17 cial Security Act) than the standards and meth-
18 odologies that applied under such programs
19 with respect to such individuals as of July 1,
20 2003.

21 “(2) DETERMINATION OF ELIGIBILITY.—

22 “(A) SCHIP AGENCY.—

23 “(i) IN GENERAL.—The determination
24 of whether an individual is an eligible low-
25 income individual for purposes of this sec-

1 tion shall be made by the State agency
2 with responsibility for determining the eli-
3 gibility of individuals for assistance under
4 the State children’s health insurance pro-
5 gram under title XXI of the Social Secu-
6 rity Act.

7 “(ii) APPLICATION OF SCREEN AND
8 ENROLL REQUIREMENTS.—

9 “(I) IN GENERAL.—The State
10 agency referred to in clause (i) shall
11 ensure that individuals applying for a
12 certificate of eligibility are screened
13 for potential eligibility under the med-
14 icaid and State children’s health in-
15 surance programs and that individuals
16 found through screening to be eligible
17 for assistance under such a program
18 are enrolled for assistance under the
19 appropriate program. To the max-
20 imum extent possible pursuant to
21 State options under title XIX of the
22 Social Security Act, and notwith-
23 standing any otherwise applicable pro-
24 vision of, or State plan provision
25 under, such title, screening and enroll-

1 ment activities described in the pre-
2 vious sentence shall use the proce-
3 dures employed by the State chil-
4 dren’s health insurance program oper-
5 ated under title XXI of the Social Se-
6 curity Act, if such procedures differ
7 from those ordinarily employed by the
8 State program operated under title
9 XIX of such Act.

10 “(II) NO DELAY OF ISSUANCE OF
11 CERTIFICATE.—The application of the
12 screen and enroll requirements of
13 clause (i) shall not delay the issuance
14 of a certificate of eligibility to an indi-
15 vidual for purposes of this section.
16 The State agency referred to in clause
17 (i) shall adopt procedures to ensure
18 that an individual issued a certificate
19 of eligibility under this paragraph who
20 is subsequently determined to be eligi-
21 ble for the State medicaid program
22 under title XIX of the Social Security
23 Act or the State children’s health in-
24 surance program under XXI of such
25 Act shall be enrolled in the appro-

1 priate program without an interrup-
2 tion in the individual’s health insur-
3 ance coverage.

4 “(B) STANDARDS.—

5 “(i) IN GENERAL.—An individual is
6 an eligible low-income individual for pur-
7 poses of this section if—

8 “(I) on the basis of the individ-
9 ual’s tax return for the preceding tax-
10 able year, the individual meets the re-
11 quirements of paragraph (1)(B), and
12 the individual otherwise satisfies the
13 requirements of paragraph (1), or

14 “(II) the individual is determined
15 to satisfy the requirements of para-
16 graph (1) after the application of the
17 same eligibility methodologies as
18 would apply for purposes of deter-
19 mining the eligibility of an individual
20 for assistance under the State chil-
21 dren’s health insurance program
22 under title XXI of the Social Security
23 Act.

24 “(ii) APPLICATION OF SCHIP INCOME
25 DETERMINATION METHODOLOGIES.—For

1 purposes of clause (i)(II), determinations
2 of income levels shall be made using the
3 methodologies described in that clause, to
4 the extent such methodologies for
5 ascertaining household income differ from
6 any otherwise applicable method for deter-
7 mining adjusted gross income or the defini-
8 tion of adjusted gross income.

9 “(C) CERTIFICATE OF ELIGIBILITY.—

10 “(i) IN GENERAL.—An individual who
11 is determined to be an eligible low-income
12 individual shall be issued a certificate of
13 eligibility by the State agency referred to
14 in subparagraph (A).

15 “(ii) CERTIFICATE AMOUNT.—Such
16 certificate shall indicate the applicable per-
17 centage of the amount paid for coverage
18 under qualified health insurance that the
19 individual is eligible for under this section
20 (including any supplemental assistance
21 which the individual may be eligible for
22 under subsection (b)(2), unless the indi-
23 vidual elects to not receive such supple-
24 mental assistance).

1 “(iii) 12-MONTH PERIOD OF ISSUE.—

2 The certificate of eligibility shall apply for
3 a 12-month period from the date of issue,
4 notwithstanding any changes in household
5 circumstances following the individual’s ap-
6 plication for a credit under this section or
7 supplemental assistance.

8 “(D) SUPPLEMENTAL ASSISTANCE.—The
9 State agency described in subparagraph (A)
10 shall determine an individual’s eligibility for
11 supplemental assistance under subsection (b)(2)
12 based on the methodologies referred to in sub-
13 paragraph (B)(ii).

14 “(f) QUALIFYING FAMILY MEMBER.—For purposes
15 of this section—

16 “(1) IN GENERAL.—The term ‘qualifying family
17 member’ means—

18 “(A) the taxpayer’s spouse; and

19 “(B) any dependent of the taxpayer with
20 respect to whom the taxpayer is entitled to a
21 deduction under section 151(c).

22 Such term does not include any individual who is
23 not an eligible low-income individual under sub-
24 section (e)(1).

1 “(2) SPECIAL DEPENDENCY TEST IN CASE OF
2 DIVORCED PARENTS, ETC.—If paragraph (2) or (4)
3 of section 152(e) applies to any child with respect to
4 any calendar year, in the case of any taxable year
5 beginning in such calendar year, such child shall be
6 treated as described in paragraph (1)(B) with re-
7 spect to the custodial parent (within the meaning of
8 section 152(e)(1)) and not with respect to the non-
9 custodial parent.

10 “(g) QUALIFIED HEALTH INSURANCE.—For pur-
11 poses of this section—

12 “(1) IN GENERAL.—The term ‘qualified health
13 insurance’ means any of the following:

14 “(A) Coverage under an insurance plan
15 participating in a purchasing pool established
16 pursuant to section 203 of the Health Cov-
17 erage, Affordability, Responsibility, and Equity
18 Act of 2003.

19 “(B) Coverage under individual health in-
20 surance pursuant to section 212 of such Act.

21 “(C) Coverage, pursuant to section 213 of
22 such Act, under the medicaid program or the
23 State children’s health insurance program if 1
24 or more family members qualifies for coverage
25 under such program.

1 “(D) Coverage, pursuant to section 214 of
2 such Act, under an employer-sponsored insur-
3 ance plan, including—

4 “(i) coverage under a COBRA con-
5 tinuation provision (as defined in section
6 9832(d)(1));

7 “(ii) State-based continuation cov-
8 erage provided under a State law that re-
9 quires such coverage;

10 “(iii) coverage voluntarily offered by a
11 former employer of the individual or family
12 member; or

13 “(iv) coverage under a group health
14 plan that is available through the employ-
15 ment of the individual or a family member.

16 “(2) EXCEPTION.—The term ‘qualified health
17 insurance’ shall not include—

18 “(A) a flexible spending or similar ar-
19 rangement; and

20 “(B) any insurance if substantially all of
21 its coverage is of excepted benefits described in
22 section 9832(c).

23 “(3) DEFINITIONS.—For purposes of this sub-
24 section—

1 “(A) EMPLOYER-SPONSORED INSUR-
2 ANCE.—

3 “(i) IN GENERAL.—The term ‘em-
4 ployer-sponsored insurance’ means any in-
5 surance which covers medical care under
6 any health plan maintained by any em-
7 ployer (or former employer) of the tax-
8 payer or the taxpayer’s spouse.

9 “(ii) TREATMENT OF CAFETERIA
10 PLANS.—For purposes of clause (i), the
11 cost of coverage shall be treated as paid or
12 incurred by an employer to the extent the
13 coverage is in lieu of a right to receive cash
14 or other qualified benefits under a cafe-
15 teria plan (as defined in section 125(d)).

16 “(B) INDIVIDUAL HEALTH INSURANCE.—
17 The term ‘individual health insurance’ means
18 any insurance which constitutes medical care
19 offered to individuals other than in connection
20 with a group health plan and does not include
21 Federal- or State-based health insurance cov-
22 erage.

23 “(h) OTHER SPECIFIED COVERAGE.—For purposes
24 of this section, an individual has other specified coverage
25 for any month if, as of the first day of such month—

1 “(1) COVERAGE UNDER MEDICARE.—Such indi-
 2 vidual is entitled to benefits under part A of title
 3 XVIII of the Social Security Act or is enrolled under
 4 part B of such title.

5 “(2) CERTAIN OTHER COVERAGE.—Such indi-
 6 vidual—

7 “(A) is enrolled in a health benefits plan
 8 under chapter 89 of title 5, United States Code;
 9 or

10 “(B) is entitled to receive benefits under
 11 chapter 55 of title 10, United States Code.

12 “(i) FEDERAL POVERTY LEVEL; POVERTY LEVEL;
 13 POVERTY.—For purposes of this section, the terms ‘Fed-
 14 eral poverty level’, ‘poverty level’, and ‘poverty’ mean the
 15 income official poverty line (as defined by the Office of
 16 Management and Budget, and revised annually in accord-
 17 ance with section 673(2) of the Omnibus Budget Rec-
 18 onciliation Act of 1981) applicable to a family of the size
 19 involved.

20 “(j) SPECIAL RULES.—

21 “(1) COORDINATION WITH ADVANCE PAYMENTS
 22 OF CREDIT.—With respect to any taxable year, the
 23 amount which would (but for this subsection) be al-
 24 lowed as a credit to the taxpayer under subsection
 25 (a) shall be reduced (but not below zero) by the ag-

gregate amount paid on behalf of such taxpayer under section 7528 for months beginning in such taxable year.

“(2) COORDINATION WITH OTHER DEDUCTIONS.—Amounts taken into account under subsection (a) shall not be taken into account in determining any deduction allowed under section 162(l) or 213.

“(3) MSA DISTRIBUTIONS.—Amounts distributed from an Archer MSA (as defined in section 220(d)) shall not be taken into account under subsection (a).

“(4) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual’s taxable year begins.

“(5) BOTH SPOUSES ELIGIBLE LOW-INCOME INDIVIDUALS.—The spouse of the taxpayer shall not be treated as a qualifying family member for purposes of subsection (a), if—

“(A) the taxpayer is married at the close of the taxable year;

1 “(B) the taxpayer and the taxpayer’s
2 spouse are both eligible low-income individuals
3 during the taxable year; and

4 “(C) the taxpayer files a separate return
5 for the taxable year.

6 “(6) MARITAL STATUS; CERTAIN MARRIED IN-
7 DIVIDUALS LIVING APART.—Rules similar to the
8 rules of paragraphs (3) and (4) of section 21(e)
9 shall apply for purposes of this section.

10 “(7) INSURANCE WHICH COVERS OTHER INDI-
11 VIDUALS.—For purposes of this section, rules simi-
12 lar to the rules of section 213(d)(6) shall apply with
13 respect to any contract for qualified health insurance
14 under which amounts are payable for coverage of an
15 individual other than the taxpayer and qualifying
16 family members.

17 “(8) TREATMENT OF PAYMENTS.—For pur-
18 poses of this section:

19 “(A) PAYMENTS BY SECRETARY.—Any
20 payment made by the Secretary on behalf of
21 any individual under section 7528 (relating to
22 advance payment of credit for health insurance
23 costs of eligible low-income individuals) shall be
24 treated as having been made by the taxpayer
25 (or on behalf of the taxpayer) on the first day

1 of the month for which such payment was
2 made.

3 “(B) PAYMENTS BY TAXPAYER.—Any pay-
4 ment made by the taxpayer (or on behalf of the
5 taxpayer) for eligible coverage months shall be
6 treated as having been so made on the first day
7 of the month for which such payment was
8 made.

9 “(9) REGULATIONS.—

10 “(A) IN GENERAL.—The Secretary, in con-
11 sultation with the Secretary of Health and
12 Human Services, shall administer the credit al-
13 lowed under this section and shall prescribe
14 such regulations and other guidance as may be
15 necessary or appropriate to carry out this sec-
16 tion, section 6050U, and section 7528.

17 “(B) ELIGIBILITY DETERMINATIONS.—
18 Such regulations shall include such standards
19 as the Secretary of Health and Human Services
20 may specify with respect to the requirements
21 for eligibility determinations under subsection
22 (e)(2).

23 “(C) MEASURES TO COMBAT FRAUD AND
24 ABUSE.—Such regulations shall include appro-
25 priate procedures to deter, detect, and penalize

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period “, or from section 36 of such Code”.

“Sec. 36. Health insurance costs of eligible low-income individuals.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2005.

(1) IN GENERAL.—The Secretary of Health and Human Services shall reimburse States for the reasonable administrative costs incurred in making eligibility determinations in accordance with section 36(e) of the Internal Revenue Code of 1986 (as added by subsection (a)). Such reimbursement shall

1 not apply to State costs required under the medicaid
 2 or State children's health insurance programs.

3 (2) APPLICATION.—A State desiring reimburse-
 4 ment under this subsection shall submit an applica-
 5 tion to the Secretary of Health and Human Services
 6 in such manner, at such time, and containing such
 7 information as the Secretary may require.

8 (3) APPROPRIATION.—Out of any money in the
 9 Treasury of the United States not otherwise appro-
 10 priated, there are appropriated such sums as may be
 11 necessary to carry out this subsection.

12 **SEC. 112. ADVANCE PAYMENT OF CREDIT FOR HEALTH IN-**
 13 **SURANCE COSTS OF ELIGIBLE LOW-INCOME**
 14 **INDIVIDUALS.**

15 (a) IN GENERAL.—Chapter 77 of the Internal Rev-
 16 enue Code of 1986 (relating to miscellaneous provisions)
 17 is amended by adding at the end the following new section:

18 **“SEC. 7528. ADVANCE PAYMENT OF CREDIT FOR HEALTH**
 19 **INSURANCE COSTS OF ELIGIBLE LOW-IN-**
 20 **COME INDIVIDUALS.**

21 “(a) GENERAL RULE.—Not later than August 1,
 22 2005, the Secretary shall establish a program for making
 23 payments on behalf of certified individuals to providers of
 24 qualified health insurance (as defined in section 36(g)) for
 25 such individuals.

1 “(b) LIMITATION ON ADVANCE PAYMENTS DURING
2 ANY TAXABLE YEAR.—The Secretary may make pay-
3 ments under subsection (a) only to the extent that the
4 total amount of such payments made on behalf of any indi-
5 vidual during the taxable year is not reasonably expected
6 to exceed the applicable percentage (as defined in section
7 36(b)) of the amount paid by the taxpayer (or on behalf
8 of the taxpayer) for coverage of the taxpayer and quali-
9 fying family members under qualified health insurance for
10 eligible coverage months beginning in the taxable year.

11 “(c) CERTIFIED INDIVIDUAL.—For purposes of this
12 section, the term ‘certified individual’ means any indi-
13 vidual for whom a health coverage eligibility certificate is
14 in effect.

15 “(d) HEALTH COVERAGE ELIGIBILITY CERTIFI-
16 CATE.—For purposes of this section, the term ‘health cov-
17 erage eligibility certificate’ means any written statement
18 that an individual is an eligible low-income individual (as
19 defined in section 36(e)) if such statement provides such
20 information as the Secretary may require for purposes of
21 this section and is issued by the State agency responsible
22 for administering the State children’s health insurance
23 program under title XXI of the Social Security Act.”.

24 (b) DISCLOSURE OF RETURN INFORMATION FOR
25 PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE

1 PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF
2 ELIGIBLE LOW-INCOME INDIVIDUALS.—

3 (1) IN GENERAL.—Subsection (l) of section
4 6103 of the Internal Revenue Code of 1986 (relating
5 to disclosure of returns and return information for
6 purposes other than tax administration) is amended
7 by adding at the end the following new paragraph:

8 “(19) DISCLOSURE OF RETURN INFORMATION
9 FOR PURPOSES OF CARRYING OUT A PROGRAM FOR
10 ADVANCE PAYMENT OF CREDIT FOR HEALTH INSUR-
11 ANCE COSTS OF ELIGIBLE LOW-INCOME INDIVID-
12 UALS.—The Secretary may disclose to providers of
13 health insurance for any certified individual (as de-
14 fined in section 7528(c)) return information with re-
15 spect to such certified individual only to the extent
16 necessary to carry out the program established by
17 section 7528 (relating to advance payment of credit
18 for health insurance costs of eligible low-income indi-
19 viduals).”.

20 (2) PROCEDURES AND RECORDKEEPING RE-
21 LATED TO DISCLOSURES.—Subsection (p) of such
22 section is amended—

23 (A) in paragraph (3)(A) by striking “or
24 (18)” and inserting “(18), or (19)”; and

(B) in paragraph (4), as amended by section 202(b)(2)(B) of the Trade Act of 2002 (Public Law 107–210; 116 Stat. 961), by striking “or (17)” after “any other person described in subsection (l)(16)” each place it appears and inserting “(18), or (19)”.

(3) UNAUTHORIZED INSPECTION OF RETURNS OR RETURN INFORMATION.—Section 7213A(a)(1)(B) of such Code is amended by striking “section 6103(n)” and inserting “subsection (l)(18) or (19) or (n) of section 6103”.

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050T the following new section:

“SEC. 6050U. RETURNS RELATING TO CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.

“(a) REQUIREMENT OF REPORTING.—Every person who is entitled to receive payments for any month of any calendar year under section 7528 (relating to advance payment of credit for health insurance costs of eligible low-

1 income individuals) with respect to any certified individual
 2 (as defined in section 7528(c)) shall, at such time as the
 3 Secretary may prescribe, make the return described in
 4 subsection (b) with respect to each such individual.

5 “(b) FORM AND MANNER OF RETURNS.—A return
 6 is described in this subsection if such return—

7 “(1) is in such form as the Secretary may pre-
 8 scribe; and

9 “(2) contains—

10 “(A) the name, address, and TIN of each
 11 individual referred to in subsection (a);

12 “(B) the number of months for which
 13 amounts were entitled to be received with re-
 14 spect to such individual under section 7528 (re-
 15 lating to advance payment of credit for health
 16 insurance costs of eligible low-income individ-
 17 uals);

18 “(C) the amount entitled to be received for
 19 each such month; and

20 “(D) such other information as the Sec-
 21 retary may prescribe.

22 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
 23 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
 24 QUIRED.—Every person required to make a return under
 25 subsection (a) shall furnish to each individual whose name

1 is required to be set forth in such return a written state-
 2 ment showing—

3 “(1) the name and address of the person re-
 4 quired to make such return and the phone number
 5 of the information contact for such person; and

6 “(2) the information required to be shown on
 7 the return with respect to such individual.

8 The written statement required under the preceding sen-
 9 tence shall be furnished on or before January 31 of the
 10 year following the calendar year for which the return
 11 under subsection (a) is required to be made.”.

12 (2) ASSESSABLE PENALTIES.—

13 (A) Subparagraph (B) of section
 14 6724(d)(1) of such Code (relating to defini-
 15 tions) is amended by redesignating clauses (xii)
 16 through (xviii) as clauses (xiii) through (xix),
 17 respectively, and by inserting after clause (xi)
 18 the following new clause:

19 “(xii) section 6050U (relating to re-
 20 turns relating to credit for health insur-
 21 ance costs of eligible low-income individ-
 22 uals),”.

23 (B) Paragraph (2) of section 6724(d) of
 24 such Code is amended by striking “or” at the
 25 end of subparagraph (AA), by striking the pe-

1 riod at the end of subparagraph (BB) and in-
 2 serting “, or”, and by adding after subpara-
 3 graph (BB) the following new subparagraph:

4 “(CC) section 6050U (relating to returns
 5 relating to credit for health insurance costs of
 6 eligible low-income individuals).”.

7 (d) CLERICAL AMENDMENTS.—

8 (1) ADVANCE PAYMENT.—The table of sections
 9 for chapter 77 of the Internal Revenue Code of 1986
 10 is amended by adding at the end the following new
 11 item:

 “Sec. 7528. Advance payment of credit for health insurance costs
 of eligible low-income individuals.”.

12 (2) INFORMATION REPORTING.—The table of
 13 sections for subpart B of part III of subchapter A
 14 of chapter 61 of such Code is amended by inserting
 15 after the item relating to section 6050T the fol-
 16 lowing new item:

 “Sec. 6050U. Returns relating to credit for health insurance costs
 of eligible low-income individuals.”.

17 (e) EFFECTIVE DATE.—The amendments made by
 18 this section shall take effect on January 1, 2006.

19 **TITLE II—IMPROVING ACCESS** 20 **TO HEALTH PLANS**

21 **SEC. 201. DEFINITIONS.**

22 In this title:

1 (1) ELIGIBLE INDIVIDUAL.—The term “eligible
2 individual” means an individual with respect to
3 whom a tax credit is allowed under section 36 of the
4 Internal Revenue Code of 1986 (as added by section
5 111).

6 (2) PARTICIPATING INSURER.—The term “par-
7 ticipating insurer” means an entity with a contract
8 under section 205(a).

9 (3) PRIVATE GROUP HEALTH INSURANCE
10 PLAN.—The term “private group health insurance
11 plan” means a plan offered by a participating in-
12 surer that provides health benefits coverage to eligi-
13 ble individuals and that meets the requirements of
14 this title.

15 (4) PURCHASING POOL OPERATOR.—The term
16 “purchasing pool operator” means the entity des-
17 ignated by the State under section 204.

18 (5) SECRETARY.—The term “Secretary” means
19 the Secretary of Health and Human Services.

20 (6) SMALL EMPLOYER.—The term “small em-
21 ployer” means an employer with not less than 2 and
22 not more than 100 employees.

1 **SEC. 202. ESTABLISHMENT OF HEALTH INSURANCE PUR-**
 2 **CHASING POOLS.**

3 There is established a program under which the Sec-
 4 retary shall ensure that each eligible individual has the
 5 opportunity to enroll, through a purchasing pool operator,
 6 in a private group health insurance plan offered by a par-
 7 ticipating insurer under this title.

8 **SEC. 203. PURCHASING POOLS.**

9 (a) ESTABLISHMENT OF PURCHASING POOLS.—Each
 10 State participating in the program under this title shall
 11 establish a purchasing pool that is available to each eligi-
 12 ble individual who resides in the State.

13 (b) TYPES OF PURCHASING POOLS.—

14 (1) IN GENERAL.—A purchasing pool estab-
 15 lished under subsection (a) shall be 1 of the fol-
 16 lowing:

17 (A) A statewide purchasing pool operated
 18 by the State.

19 (B) A statewide purchasing pool operated
 20 on behalf of the State by the Director of the
 21 Office of Personnel Management, or the des-
 22 ignee of such Director.

23 (2) OPM OPERATED POOL.—In the case of a
 24 statewide purchasing pool described in paragraph
 25 (1)(B), the Director of the Office of Personnel Man-
 26 agement or the Director's designee, may limit par-

1 participating insurers in such pool to those described in
2 section 205(e), except that the Director or such des-
3 ignee shall ensure that additional private group
4 health insurance plans participate in such a pool to
5 the extent necessary to meet the requirements of
6 section 204(c)(9).

7 (c) STATE ELECTION PROCESS.—

8 (1) IN GENERAL.—Each State participating in
9 the program under this title shall notify the Sec-
10 retary, not later than January 4, 2005, of the type
11 of purchasing pool that applies to residents of the
12 State.

13 (2) DEFAULT CHOICE.—If a State participating
14 in the program under this title fails to notify the
15 Secretary of the type of purchasing pool elected by
16 the State by the date described in paragraph (1),
17 the State shall be deemed to have elected the type
18 of purchasing pool described in subsection (b)(1)(B).

19 (3) CHANGE OF ELECTION.—The Secretary
20 shall establish procedures under which a State par-
21 ticipating in the program under this title may
22 change the election of the type of purchasing pool
23 applicable to residents of the State.

1 **SEC. 204. PURCHASING POOL OPERATORS.**

2 (a) DESIGNATION.—Each State shall designate a
3 purchasing pool operator that shall be responsible for op-
4 erating the purchasing pool established under section
5 203(a). A purchasing pool operator may be (or, to have
6 1 or more of its functions performed, may contract with)
7 a private entity that has entered into a contract with the
8 State if such entity meets requirements established by the
9 Secretary for purposes of the program under this title.

10 (b) OPERATION SIMILAR TO FEHBP.—Each pur-
11 chasing pool operator shall operate the purchasing pool
12 established under section 203(a) in a manner that is simi-
13 lar to the manner in which the Director of the Office of
14 Personnel Management operates the Federal employees'
15 health benefits program under chapter 89 of title 5,
16 United States Code, including (but not limited to) the per-
17 formance of the specific functions described in subsection
18 (c).

19 (c) SPECIFIC FUNCTIONS DESCRIBED.—The specific
20 functions described in this subsection include the fol-
21 lowing:

22 (1) Each purchasing pool operator shall offer
23 one-stop shopping for eligible individuals to enroll
24 for health benefits coverage under private, group
25 health insurance plans offered by participating in-
26 surers.

1 (2) Each purchasing pool operator shall limit
2 participating insurers to those that meet the condi-
3 tions for participation described in this title.

4 (3) Each purchasing pool operator shall nego-
5 tiate (or, in the case of a purchasing pool described
6 in section 203(b)(1)(B), shall negotiate or otherwise
7 determine) bids and terms of coverage with insurers.

8 (4) Each purchasing pool operator shall provide
9 eligible individuals with comparative information on
10 private group health insurance plans offered by par-
11 ticipating insurers.

12 (5) Each purchasing pool operator shall assist
13 eligible individuals in enrolling with a private group
14 health insurance plan offered by a participating in-
15 surer.

16 (6) Each purchasing pool operator shall collect
17 private group health insurance plan premium pay-
18 ments for participating insurers and process such
19 premium payments.

20 (7) Each purchasing pool operator shall rec-
21 oncile from year to year aggregate premium pay-
22 ments and claims costs of private group health in-
23 surance plans consistent with practices under the
24 Federal employees' health benefits program under
25 chapter 89 of title 5, United States Code.

1 (8) Each purchasing pool operator shall offer
2 customer service to eligible individuals enrolled for
3 health benefits coverage under a private group
4 health insurance plan offered by a participating in-
5 surer.

6 (9) Each purchasing pool operator shall ensure
7 that each eligible individual has the option of enroll-
8 ing in either of at least 2 benchmark or benchmark-
9 equivalent plans with—

10 (A) a premium at or below a cap estab-
11 lished by the pool operator for purposes of this
12 title; and

13 (B) coverage of essential services included
14 in the report required under section 301(e)(2),
15 with cost-sharing consistent with such report.

16 (10) Each purchasing pool operator shall estab-
17 lish a premium cap for purposes of determining the
18 credit limitation under section 36(c) of the Internal
19 Revenue Code of 1986, as added by section 111(a).
20 The cap required under this paragraph may not be
21 less than the premium charged to Federal employees
22 by the most highly-enrolled health plan under the
23 Federal employees' health benefits program under
24 chapter 89 of title 5, United States Code. If the
25 most highly-enrolled plan in that program differs for

1 Federal enrollees in the State and all Federal enroll-
2 ees nationally in such plan, the minimum permitted
3 premium cap shall be the lower of such premiums.

4 **SEC. 205. CONTRACTS WITH PARTICIPATING INSURERS.**

5 (a) IN GENERAL.—Each purchasing pool operator
6 shall negotiate and enter into contracts for the provision
7 of health benefits coverage under the program under this
8 title with entities that meet the conditions of participation
9 described in subsection (b) and other applicable require-
10 ments of this Act.

11 (b) CONSUMER INFORMATION.—In carrying out its
12 duty under section 204(c)(4) to inform eligible individuals
13 about private group health plans, the purchasing pool op-
14 erator shall provide information that meets the require-
15 ments of section 212(b)(2).

16 (c) STATE LICENSURE.—

17 (1) IN GENERAL.—Subject to paragraph (2), a
18 health plan shall not be a participating insurer un-
19 less the plan has a State license to provide State
20 residents with the private group coverage health in-
21 surance plans that it offers through the pool.

22 (2) EXCEPTION.—A pool operator may enter
23 into a contract under subsection (a) to cover pool
24 participants through a health plan without a State
25 license described in paragraph (1) if such plan is of-

1 ferred to Federal employees nationwide and, with re-
2 spect to such employees, is exempt from State health
3 insurance regulation. Nothing in this paragraph
4 shall be construed to permit coverage of pool partici-
5 pants through such a plan except with groups, con-
6 tracts, and premium rates that are entirely distinct
7 from those used for individuals covered under the
8 Federal employee's health benefits program under
9 chapter 89 of title 5, United States Code.

10 (d) ADDITIONAL STOP-LOSS COVERAGE AND REIN-
11 SURANCE.—Purchasing pool operators are authorized to
12 encourage participation in the program under this title,
13 improve covered benefits, reduce out-of-pocket cost-shar-
14 ing, limit premiums, or achieve other objectives of this Act
15 by—

16 (1) funding stop-loss coverage above levels oth-
17 erwise offered in the purchasing pool; or

18 (2) providing or subsidizing reinsurance in ad-
19 dition to that provided under section 211.

20 (e) PARTICIPATION OF FEHBP PLANS.—

21 (1) IN GENERAL.—Each entity with a contract
22 under section 8902 of title 5, United States Code,
23 shall be a participating insurer unless such entity
24 notifies the Secretary in writing of its intention not
25 to participate in the program under this title prior

1 to such time as is designated by the Secretary so
2 as to allow such decisions to be taken into account
3 with respect to eligible individuals' choice of a pri-
4 vate group health insurance plan under such pro-
5 gram. Such participation in the program under this
6 title shall include at least the covered benefits and
7 provider networks available through such an entity
8 and shall not involve greater out-of-pocket cost-shar-
9 ing than the plan offered by such entity pursuant
10 to its contract under section 8902 of title 5, United
11 States Code.

12 (2) NO EFFECT ON FEHBP COVERAGE.—The
13 Director of Office of Personnel Management shall
14 take such steps as are necessary to ensure that each
15 individual enrolled for health benefits coverage under
16 the program under chapter 89 of title 5, United
17 States Code, is not adversely affected by eligible in-
18 dividuals or others enrolled for coverage under the
19 program under this title. Such steps shall include
20 (but need not be limited to) the establishment of
21 separate risk pools, separate contracts with partici-
22 pating insurers, and separately negotiated pre-
23 miums.

1 **SEC. 206. OPTIONS FOR HEALTH BENEFITS COVERAGE.**

2 (a) SCOPE OF HEALTH BENEFITS COVERAGE.—The
3 health benefits coverage provided to an eligible individual
4 under a private group health insurance plan offered by
5 a participating insurer shall consist of any of the fol-
6 lowing:

7 (1) BENCHMARK COVERAGE.—Health benefits
8 coverage that is equivalent to the benefits coverage
9 in a benchmark benefit package described in sub-
10 section (b).

11 (2) BENCHMARK-EQUIVALENT COVERAGE.—
12 Health benefits coverage that meets the following re-
13 quirements:

14 (A) INCLUSION OF ESSENTIAL SERV-
15 ICES.—The coverage includes each of the essen-
16 tial services identified by the National Advisory
17 Commission on Expanded Access to Health
18 Care and adopted by Congress under title III.

19 (B) AGGREGATE ACTUARIAL VALUE EQUIV-
20 ALENT TO BENCHMARK PACKAGE.—The cov-
21 erage has an aggregate actuarial value that is
22 equal to or greater than the actuarial value of
23 one of the benchmark benefit packages.

24 (3) ALTERNATIVE COVERAGE.—Any other
25 health benefits coverage that the Secretary deter-
26 mines, upon application by a State, offers health

1 benefits coverage equivalent to or greater than a
2 plan described in and offered under section 8903(1)
3 of title 5, United States Code.

4 (b) BENCHMARK BENEFIT PACKAGES.—The bench-
5 mark benefit packages are as follows:

6 (1) FEHBP-EQUIVALENT HEALTH BENEFITS
7 COVERAGE.—The plan described in and offered
8 under chapter 89 of title 5, United States Code with
9 the highest number of enrollees under such section
10 for the year preceding the year in which the private
11 group health insurance plan is proposed to be of-
12 fered.

13 (2) PUBLIC PROGRAM-EQUIVALENT HEALTH
14 BENEFITS COVERAGE.—Coverage provided under the
15 State plan approved under the medicaid program
16 under title XIX of the Social Security Act or the
17 State children’s health insurance program under
18 title XXI of such Act (42 U.S.C. 1396 et seq.,
19 1397aa et seq.) (without regard to coverage provided
20 under a waiver of the requirements of either such
21 program).

22 (3) COVERAGE OFFERED THROUGH HMO.—The
23 health insurance coverage plan that—

24 (A) is offered by a health maintenance or-
25 ganization (as defined in section 2791(b)(3) of

1 the Public Health Service Act (42 U.S.C. 33gg–
2 91(b)(3))); and

3 (B) has the largest insured commercial,
4 nonmedicaid enrollment of covered lives of such
5 coverage plans offered by such a health mainte-
6 nance organization in the State.

7 (4) STATE EMPLOYEE COVERAGE.—The health
8 insurance plan that is offered to State employees
9 and has the largest enrollment of covered lives of
10 any such plan.

11 (5) APPLICATION OF BENCHMARK STAND-
12 ARDS.—A private group health plan offers bench-
13 mark benefits if, with respect to a benchmark plan
14 described in paragraph (1), (2), (3), or (4), the pri-
15 vate group health plan covers all items and services
16 offered by the benchmark plan, with out-of-pocket
17 cost-sharing for such items and services that is not
18 greater than under the benchmark plan. Nothing in
19 this title shall be construed to forbid a private group
20 health plan from offering additional items and serv-
21 ices not covered by such a benchmark plan or reduc-
22 ing out-of-pocket cost-sharing below levels applicable
23 under such plan.

1 **SEC. 207. ENROLLMENT PROCESS FOR ELIGIBLE INDIVID-**
2 **UALS.**

3 (a) IN GENERAL.—The Secretary shall establish a
4 process through which an eligible individual—

5 (1) may make an annual election to enroll in
6 any private group health insurance plan offered by
7 a participating insurer that has been awarded a con-
8 tract under section 205(a) and serves the geographic
9 area in which the individual resides, provided that
10 such insurer's geographic area of service and guar-
11 anteed issuance under this section is conterminous
12 with, or includes all of, a geographic area served
13 pursuant to an entity's contract under section 8902
14 of title 5, United States Code; and

15 (2) may make an annual election to change the
16 election under this clause.

17 (b) RULES.—In establishing the process under sub-
18 section (a), the Secretary shall use rules similar to the
19 rules for enrollment, disenrollment, and termination of en-
20 rollment under the Federal employees health benefits pro-
21 gram under chapter 89 of title 5, United States Code, in-
22 cluding the application of the guaranteed issuance provi-
23 sion described in subsection (c).

24 (c) GUARANTEED ISSUANCE.—An eligible individual
25 who is eligible to enroll for health benefits coverage under
26 a private group health insurance plan that has been

1 awarded a contract under section 205(a) at a time during
 2 which elections are accepted under this title with respect
 3 to the plan shall not be denied enrollment based on any
 4 health status-related factor (described in section
 5 2702(a)(1) of the Public Health Service Act (42 U.S.C.
 6 300gg-1(a)(1))) or any other factor.

7 **SEC. 208. PLAN PREMIUMS.**

8 (a) IN GENERAL.—Each purchasing pool operator
 9 shall negotiate (or, in the case of a purchasing pool oper-
 10 ated pursuant to section 203(b)(1)(B), shall otherwise de-
 11 termine) a premium for each private group health insur-
 12 ance plan offered by a participating insurer.

13 (b) PERMITTED PROFIT MARGINS.—

14 (1) IN GENERAL.—Each premium negotiated
 15 under subsection (a) may not permit a profit margin
 16 that exceeds the applicable percentage (as defined in
 17 paragraph (2)).

18 (2) APPLICABLE PERCENTAGE DEFINED.—In
 19 this subsection, the term “applicable percentage”
 20 means—

21 (A) for the first 3 years that a purchasing
 22 pool is operated, 2 percent;

23 (B) for any subsequent year, the percent-
 24 age determined by the purchasing pool oper-
 25 ator, which may not be—

1 (i) less than the profit margin per-
 2 mitted under the Federal employees health
 3 benefits program under chapter 89 of title
 4 5, United States Code; or

5 (ii) more than a multiple, established
 6 by the Secretary for purposes of this sub-
 7 section, of profit margins permitted under
 8 such program.

9 **SEC. 209. ENROLLEE PREMIUM SHARE.**

10 (a) IN GENERAL.—A participating insurer offering a
 11 private group health insurance plan that has been awarded
 12 a contract under section 205(a) in which the eligible indi-
 13 vidual is enrolled may not deny, limit, or condition the
 14 coverage (including out-of-pocket cost-sharing) or provi-
 15 sion of health benefits coverage or vary or increase the
 16 enrollee premium share under the plan based on any
 17 health status-related factor described in section
 18 2702(a)(1) of the Public Health Service Act (42 U.S.C.
 19 300gg–1(a)(1)) or any other factor.

20 (b) RISK-ADJUSTED PLAN PAYMENTS AND PRE-
 21 MIUMS CHARGED TO ENROLLEES.—

22 (1) IN GENERAL.—For each private group
 23 health insurance plan operated by a participating in-
 24 surer, the pool operator shall adjust premium pay-
 25 ments to compensate for the difference in health risk

1 factors between plan enrollees and State residents as
2 a whole (including residents who are not eligible in-
3 dividuals). Such adjustments shall employ risk-ad-
4 justment mechanisms promulgated by the Secretary.

5 (2) ADDITIONAL ADJUSTMENTS.—The pool op-
6 erator shall also provide additional adjustments to
7 premium payments that compensate participating in-
8 surers for the cost of keeping out-of-pocket cost-
9 sharing amounts consistent with section
10 204(c)(9)(B).

11 (3) ENROLLEE PREMIUM COSTS.—The adjust-
12 ments described in this subsection shall not affect
13 enrollee premium shares, which shall be based on the
14 premium that would be charged for enrollees with
15 health risk factors for State residents as a whole (as
16 described in paragraph (1)), without taking into ac-
17 count cost-sharing adjustments under section
18 204(c)(9)(B).

19 (c) AMOUNT OF PREMIUM.—The amount of the en-
20 rollee premium share shall be equal to premium amounts
21 (if any) above the applicable cap set pursuant to section
22 204(c)(10), plus 100 percent of the remainder minus the
23 applicable percentage (as defined in section 36(b) of the
24 Internal Revenue Code of 1986, as added by section 111).

1 **SEC. 210. PAYMENTS TO PURCHASING POOL OPERATORS**
2 **AND PAYMENTS TO PARTICIPATING INSUR-**
3 **ERS.**

4 The Secretary shall establish procedures for making
5 payments to each purchasing pool operator as follows:

6 (1) **RISK-ADJUSTMENT PAYMENT.**—The Sec-
7 retary shall pay each purchasing pool operator for
8 the net costs of risk-adjusted payments to plans
9 under section 209(b), to the extent the sum of up-
10 ward adjustments exceeds the sum of downward ad-
11 justments for the pool operator.

12 (2) **STOP-LOSS AND REINSURANCE PAY-**
13 **MENTS.**—

14 (A) **IN GENERAL.**—The Secretary shall pay
15 each purchasing pool operator for the applicable
16 percentage (as defined in subparagraph (B))
17 of—

18 (i) the costs of any stop-loss coverage
19 funded by the purchasing pool operator
20 under section 205(d)(1); and

21 (ii) any reinsurance provided in ac-
22 cordance with section 205(d)(2).

23 (B) **APPLICABLE PERCENTAGE DE-**
24 **FINED.**—In this paragraph, the term “applica-
25 ble percentage” means—

- 1 (i) for the first 3 years that a pur-
2 chasing pool is operated, 100 percent;
3 (ii) for the next 2 years that such
4 purchasing pool is operated, 50 percent;
5 and
6 (iii) for any subsequent year, 0 per-
7 cent.

8 (3) PAYMENTS NECESSARY TO KEEP COST-
9 SHARING WITHIN APPLICABLE LIMITS.—The Sec-
10 retary shall make payments to purchasing pool oper-
11 ators to reimburse purchasing pool operators for the
12 amount paid by such operators to participating in-
13 surers necessary to keep out-of-pocket cost-sharing
14 for individuals with limited ability to pay within ap-
15 plicable limits.

16 (4) PAYMENT FOR ADMINISTRATIVE COSTS.—
17 The Secretary shall make payments to each pur-
18 chasing pool operator for necessary pool administra-
19 tive expenses.

20 (5) PAYMENTS TO OPM.—In the case of a pur-
21 chasing pool described in section 203(b)(1)(B), pay-
22 ments under this section shall be made to the Direc-
23 tor of the Office of Personnel Management.

1 **SEC. 211. STATE-BASED REINSURANCE PROGRAMS.**

2 (a) ESTABLISHMENT.—The Secretary shall establish
3 standards for State-based reinsurance programs for eligi-
4 ble individuals to guard against adverse selection and to
5 improve the functioning of the individual health insurance
6 market.

7 (b) GRANTS FOR STATEWIDE REINSURANCE PRO-
8 GRAMS.—

9 (1) IN GENERAL.—The Secretary may award
10 grants to States for the reasonable costs incurred in
11 providing reinsurance under this section, consistent
12 with standards developed by the Secretary, for cov-
13 erage offered in the individual health insurance mar-
14 ket and through State-based purchasing pools de-
15 scribed in section 203.

16 (2) LIMITATION.—Such grants may not pay for
17 reinsurance extending beyond individuals in the top
18 3 percent of the national health care spending dis-
19 tribution, as determined by the Secretary.

20 (3) APPLICATION.—A State desiring a grant
21 under this section shall submit an application to the
22 Secretary in such manner, at such time, and con-
23 taining such information as the Secretary may re-
24 quire.

25 (4) AUTHORIZATION OF APPROPRIATIONS.—
26 There are authorized to be appropriated to the Sec-

1 retary such sums as may be necessary for making
2 grants under this section.

3 **SEC. 212. COVERAGE UNDER INDIVIDUAL HEALTH INSUR-**
4 **ANCE.**

5 (a) IN GENERAL.—Eligible individuals may use cred-
6 its allowed under the Internal Revenue Code of 1986 (in-
7 cluding supplemental assistance provided under such
8 Code) for the purchase of health insurance coverage to en-
9 roll in State-licensed individual health insurance meeting
10 the conditions of participation described in subsection (b).

11 (b) CONDITIONS OF PARTICIPATION.—The Secretary
12 shall promulgate regulations that establish the terms and
13 conditions under which an entity may participate in the
14 program under this section and that include the following:

15 (1) PLAN MARKETING.—Conditions of partici-
16 pation for plans in the individual market (as devel-
17 oped by the Secretary) that—

18 (A) ensure that consumers receive the con-
19 sumer information described in paragraph (2)
20 before selecting a plan; and

21 (B) detect, deter, and penalize marketing
22 fraud by entities offering or purporting to offer
23 individual insurance.

24 (2) CONSUMER INFORMATION.—Requirements
25 for each entity offering individual insurance to pro-

1 vide eligible individuals with information in a uni-
2 form and easily comprehensible manner that allows
3 for informed comparisons by eligible individuals and
4 that includes information regarding the health bene-
5 fits coverage, costs, provider networks, quality, the
6 amount and proportion of health insurance premium
7 payments that go directly to patient care, and the
8 plan's coverage rules (including amount, duration,
9 and scope limits) and out-of-pocket cost-sharing
10 (both inside and outside plan networks) for each es-
11 sential service recommended by the National Advi-
12 sory Commission on Expanded Access to Health
13 Care and adopted by Congress under title III (which
14 shall be prominently identified as an essential serv-
15 ice, including by reference to the Commission rec-
16 ommendation denoting the service as essential). To
17 the maximum extent feasible, such requirements
18 shall specify that the content and presentation of the
19 information shall be provided in the same manner as
20 similar information is presented to enrollees in the
21 Federal employees health benefits program under
22 chapter 89 of title 5, United States Code.

23 (3) OTHER CONDITIONS, INCLUDING THE
24 ELIMINATION OF BARRIERS TO AFFORDABLE COV-
25 ERAGE.—

1 (A) IN GENERAL.—Requirements for each
2 entity offering individual insurance to abide by
3 conditions of participation that the Secretary
4 believes are reasonable and appropriate meas-
5 ures to address barriers to affordable health in-
6 surance coverage.

7 (B) SPECIFIC CONDITIONS.—The require-
8 ments developed by the Secretary under sub-
9 paragraph (A) shall include (but need not be
10 limited to)—

11 (i) guaranteed renewability, without
12 premium increases based on changed indi-
13 vidual risk; and

14 (ii) limits on risk rating.

15 (4) RULE OF CONSTRUCTION.—Nothing in this
16 section shall be construed to authorize the Secretary
17 to impose any requirements on individual insurance,
18 except with respect to eligible individuals purchasing
19 individual insurance using advance payment of a tax
20 credit provided under section 36 of the Internal Rev-
21 enue Code of 1986.

1 **SEC. 213. USE OF PREMIUM SUBSIDIES TO UNIFY FAMILY**
2 **COVERAGE WITH MEMBERS ENROLLED IN**
3 **MEDICAID AND SCHIP.**

4 Notwithstanding any other provision of law, the Sec-
5 retary shall establish procedures under which, in the case
6 of a family with 1 or more members enrolled in with a
7 managed care entity under the State medicaid program
8 under title XIX of the Social Security Act or the State
9 children's health insurance program under title XXI of
10 such Act (42 U.S.C. 1396 et seq., 1397aa et seq.) and
11 1 or more members who are an eligible individual under
12 this title, the family shall have the option to enroll all fam-
13 ily members with the managed care entity under either
14 or both such State programs. The procedures established
15 by the Secretary shall provide that premiums charged to
16 eligible individuals for enrollment with such an entity shall
17 be based on the capitated payments established for adults
18 or children, excluding adults and children who are known
19 to be pregnant, blind, disabled, or (in the case of adults)
20 elderly, under the applicable State program (except that,
21 in the case of an eligible individual known to be pregnant,
22 premiums shall reflect capitated payments established
23 under such State program for individuals known to be
24 pregnant) plus reasonable administrative costs.

1 **SEC. 214. COVERAGE THROUGH EMPLOYER-SPONSORED**
2 **HEALTH INSURANCE.**

3 (a) IN GENERAL.—Eligible individuals may use cred-
4 its allowed under the Internal Revenue Code of 1986 and
5 supplemental assistance to enroll in coverage offered by
6 eligible employers.

7 (b) ELIGIBLE EMPLOYERS.—For purposes of this
8 section, the term “eligible employers” includes the fol-
9 lowing:

10 (1) The current employer of the eligible indi-
11 vidual or a member of such individual’s family.

12 (2) A former employer required to offer cov-
13 erage of the eligible individual under a COBRA con-
14 tinuation provision (as defined in section 9832(d)(1)
15 of the Internal Revenue Code) or a State law requir-
16 ing continuation coverage; and

17 (3) A former employer voluntarily offering cov-
18 erage of the eligible individual.

19 (c) APPLICATION OF DISREGARD OF PREEXISTING
20 CONDITIONS EXCLUSIONS.—Notwithstanding any other
21 provision of law, in the case of an individual who experi-
22 ences a qualifying event (as defined in section 603 of the
23 Employee Retirement Income Security Act of 1974 (29
24 U.S.C. 1163) and who, not later than 6 months after such
25 event, is determined to be an eligible individual under this
26 title, the same rules with respect to preexisting conditions

1 as apply to a nonelecting TAA-eligible individual under
2 section 605(b) of the Employee Retirement Income Secu-
3 rity Act of 1974 (29 U.S.C. 1165(b)) shall apply with re-
4 spect to such individual, regardless of which type of quali-
5 fied coverage the individual purchases.

6 (d) EXTENSION OF COBRA ELECTION PERIOD.—
7 Notwithstanding any other provision of law, in the case
8 of an individual who experiences a qualifying event (as de-
9 fined in section 603 of the Employee Retirement Income
10 Security Act of 1974 (29 U.S.C. 1163) and who, not later
11 than 6 months after such event, is determined to be an
12 eligible individual under this title, the same rules with re-
13 spect to the temporary extension of a COBRA election pe-
14 riod as apply to a nonelecting TAA-eligible individual
15 under section 605(b) of the Employee Retirement Income
16 Security Act of 1974 (29 U.S.C. 1165(b)) shall apply with
17 respect to such individual.

18 (e) CURRENT EMPLOYER COVERAGE.—If an eligible
19 individual uses the credits allowed under the Internal Rev-
20 enue Code of 1986 and supplemental assistance to pur-
21 chase coverage from an employer described in subsection
22 (b), such credits and assistance shall apply as a percent-
23 age, not of the total premium amount for the eligible indi-
24 vidual, but of the employee's or former employee's share
25 of premium payments.

1 **SEC. 215. PARTICIPATION BY SMALL EMPLOYERS.**

2 (a) IN GENERAL.—Notwithstanding any other provi-
3 sion of this title, the Secretary shall establish procedures
4 under which, during annual open enrollment periods, a
5 small employer shall have the option of purchasing group
6 coverage for employees and dependents of employees, in-
7 cluding individuals who are not otherwise eligible individ-
8 uals under this title, through a purchasing pool established
9 under section 203(a).

10 (b) CONDITIONS OF PARTICIPATION.—

11 (1) IN GENERAL.—Except as otherwise pro-
12 vided in this subsection, the same requirements that
13 apply with respect to participating insurers covering
14 eligible low-income individuals under section 203
15 shall apply with respect to coverage offered by such
16 insurers through a small employer.

17 (2) RISK ADJUSTMENT.—

18 (A) INCREASED PAYMENTS.—If employees
19 of a small employer who are not otherwise eligi-
20 ble individuals under this title enroll in a pri-
21 vate group health insurance plan under this
22 title and have a collective risk level that exceeds
23 the statewide average (as determined pursuant
24 to risk adjustment mechanisms developed by
25 the Secretary consistent with section
26 209(b)(1)), the Secretary (through a pool oper-

1 ator) shall provide participating insurers with
2 such small employer enrollment bonus payments
3 as are necessary to compensate the insurers for
4 such increased risk. The premium charged to
5 enrollees under this section shall be the same
6 premium that is the basis of premium charges
7 to enrollees who are eligible low-income individ-
8 uals.

9 (B) REDUCED PAYMENTS.—A pool oper-
10 ator shall reduce payments to any plan with a
11 risk level that falls below the statewide average
12 (as so determined).

13 (3) ADMINISTRATIVE GUIDELINES.—The Sec-
14 retary shall develop guidelines for pool operators to
15 use in serving small employers, which shall be mod-
16 eled after existing, successful, longstanding small
17 business purchasing cooperatives, and shall include
18 administratively simple methods for small employers
19 and licensed insurance brokers to participate in the
20 program established under this title.

21 (c) INFORMATION CAMPAIGN.—

22 (1) IN GENERAL.—The pool operator for a
23 State shall establish and conduct, directly or
24 through 1 or more public or private entities (which
25 may include licensed insurance brokers), a health in-

1 surance information program to inform small em-
2 ployers about health coverage for employees.

3 (2) REQUIREMENTS.—The program established
4 under paragraph (1) shall educate small employers
5 with respect to matters that include (but are not
6 limited to) the following:

7 (A) The benefits of providing health insur-
8 ance to employees, including tax benefits to
9 both the employer and employees, increased
10 productivity, and decreased employee turnover.

11 (B) The rights of small employers under
12 Federal and State health insurance reform
13 laws.

14 (C) Options for purchasing coverage, in-
15 cluding (but not limited to) through the State's
16 purchasing pool operated pursuant to section
17 203.

18 (d) GRANTS TO HELP STATE-BASED POOLS PRO-
19 MOTE SMALL BUSINESS COVERAGE.—

20 (1) IN GENERAL.—The Secretary may award
21 grants to a pool operator for the following:

22 (A) The net costs of risk-adjusted pay-
23 ments under paragraph (b)(2), to the extent the
24 sum of upward adjustments exceeds the sum of
25 downward adjustments for the pool operator.

1 (B) The reasonable cost of the information
2 campaign under subsection (c).

3 (C) The pool operator's reasonable admin-
4 istrative costs to implement this section.

5 (2) LIMITATION.—This section shall not apply
6 to a State's pool unless sufficient grant funds have
7 been received under this subsection to implement
8 this section on a fiscally sound basis and such re-
9 ceipt is certified by the pool operator.

10 (3) APPLICATION.—A pool operator desiring a
11 grant under this section shall submit an application
12 to the Secretary in such manner, at such time, and
13 containing such information as the Secretary may
14 require.

15 (4) AUTHORIZATION OF APPROPRIATIONS.—
16 There are authorized to be appropriated to the Sec-
17 retary such sums as may be necessary for making
18 grants under this section.

19 **SEC. 216. REPORT.**

20 Not later than 1 year after the date of enactment
21 of this Act, the Secretary shall submit to Congress a re-
22 port containing recommendations for such legislative and
23 administrative changes as the Secretary determines are
24 appropriate to permit affinity groups related for reasons

1 other than a common employer to participate in pur-
 2 chasing pools established under section 203.

3 **SEC. 217. AUTHORIZATION OF APPROPRIATIONS.**

4 (a) IN GENERAL.—There are authorized to be appro-
 5 priated, such sums as may be necessary to carry out this
 6 title for fiscal year 2006 and each fiscal year thereafter.

7 (b) RULE OF CONSTRUCTION.—Amounts appro-
 8 priated in accordance with subsection (a) shall be in addi-
 9 tion to other amounts appropriated directly under this
 10 title and nothing in subsection (a) shall be construed to
 11 relieve the Secretary of mandatory payment obligations re-
 12 quired under this title.

13 **TITLE III—NATIONAL ADVISORY**
 14 **COMMISSION ON EXPANDED**
 15 **ACCESS TO HEALTH CARE**

16 **SEC. 301. NATIONAL ADVISORY COMMISSION ON EXPANDED**
 17 **ACCESS TO HEALTH CARE.**

18 (a) ESTABLISHMENT.—Not later than October 1,
 19 2003, the Secretary of Health and Human Services (re-
 20 ferred to in this section as the “Secretary”), shall estab-
 21 lish an entity to be known as the National Advisory Com-
 22 mission on Expanded Access to Health Care (referred to
 23 in this section as the “Commission”).

24 (b) APPOINTMENT OF MEMBERS.—

1 (1) IN GENERAL.—Not later than 45 days after
2 the date of enactment of this Act, the House and
3 Senate Majority and Minority Leaders shall each ap-
4 point 4 members of the Commission and the Sec-
5 retary shall appoint 1 member.

6 (2) CRITERIA.—Members of the Commission
7 shall include representatives of the following:

8 (A) Consumers of health insurance.

9 (B) Health care professionals.

10 (C) State officials.

11 (D) Economists.

12 (E) Health care providers.

13 (F) Experts on health insurance.

14 (G) Experts on expanding health care to
15 individuals who are uninsured.

16 (3) CHAIRPERSON.—At the first meeting of the
17 Commission, the Commission shall select a Chair-
18 person from among its members.

19 (c) MEETINGS.—

20 (1) IN GENERAL.—After the initial meeting of
21 the Commission which shall be called by the Sec-
22 retary, the Commission shall meet at the call of the
23 Chairperson.

1 (2) QUORUM.—A majority of the members of
2 the Commission shall constitute a quorum, but a
3 lesser number of members may hold hearings.

4 (3) SUPERMAJORITY VOTING REQUIREMENT.—
5 To approve a report required under paragraph (2)
6 or (3) of subsection (e), at least 60 percent of the
7 membership of the Commission must vote in favor of
8 such a report.

9 (d) DUTIES.—The Commission shall—

10 (1) assess the effectiveness of programs de-
11 signed to expand health care coverage or make
12 health care coverage affordable to the otherwise un-
13 insured individuals through identifying the accom-
14 plishments and needed improvements of each pro-
15 gram;

16 (2) make recommendations about benefits and
17 cost-sharing to be included in health care coverage
18 for various groups, taking into account—

19 (A) the special health care needs of chil-
20 dren and individuals with disabilities;

21 (B) the different ability of various popu-
22 lations to pay out-of-pocket costs for services;

23 (C) incentives for efficiency and cost-con-
24 trol; and

1 (D) preventative care, disease management
2 services, and other factors;

3 (3) recommend mechanisms to discourage indi-
4 viduals and employers from voluntarily opting out of
5 health insurance coverage;

6 (4) recommend mechanisms to expand health
7 care coverage to uninsured individuals with incomes
8 above 200 percent of the official income poverty line
9 (as defined by the Office of Management and Budg-
10 et, and revised annually in accordance with section
11 673(2) of the Omnibus Budget Reconciliation Act of
12 1981) applicable to a family of the size involved;

13 (5) recommend automatic enrollment and reten-
14 tion procedures and other measures to increase
15 health care coverage among those eligible for assist-
16 ance;

17 (6) review the roles, responsibilities, and rela-
18 tionship between Federal and State agencies with re-
19 spect to health care coverage and recommend im-
20 provements; and

21 (7) analyze the size, effectiveness, and efficiency
22 of current tax and other subsidies for health care
23 coverage and recommend improvements.

24 (e) REPORTS.—

1 (1) ANNUAL REPORT.—The Commission shall
2 submit annual reports to the President and Con-
3 gress addressing the matters identified in subsection
4 (d).

5 (2) BIENNIAL REPORT.—

6 (A) IN GENERAL.—The Commission shall
7 submit biennial reports to the President and
8 Congress, which shall contain—

9 (i) recommendations concerning essen-
10 tial benefits and maximum out-of-pocket
11 cost-sharing (for the general population
12 and for individuals with limited ability to
13 pay, which shall not exceed the out-of-
14 pocket cost-sharing permitted under sec-
15 tion 2103(e) of the Social Security Act (42
16 U.S.C. 1397cc(e))) for the coverage op-
17 tions described in title II; and

18 (ii) proposed legislative language to
19 implement such recommendations.

20 (B) CONGRESSIONAL ACTION.—The legis-
21 lative language proposed under subparagraph
22 (A)(ii) shall proceed to immediate consideration
23 on the floor of the House of Representatives
24 and the Senate and shall be approved or re-
25 jected, without amendment, using procedures

1 employed for recommendations of military base
2 closing commissions.

3 (3) COMMISSION REPORT.—No later than Janu-
4 ary 15, 2007, the Commission shall submit a report
5 to the President and Congress, which shall include—

6 (A) recommendations on policies to provide
7 health care coverage to uninsured individuals
8 with incomes above 200 percent of the official
9 income poverty line (as defined by the Office of
10 Management and Budget, and revised annually
11 in accordance with section 673(2) of the Omni-
12 bus Budget Reconciliation Act of 1981) applica-
13 ble to a family of the size involved;

14 (B) recommendations on changes to poli-
15 cies enacted under this Act; and

16 (C) proposed legislative language to imple-
17 ment such recommendations.

18 (f) ADMINISTRATION.—

19 (1) POWERS.—

20 (A) HEARINGS.—The Commission may
21 hold such hearings, sit and act at such times
22 and places, take such testimony, and receive
23 such evidence as the Commission considers ad-
24 visable to carry out this section.

1 (B) INFORMATION FROM FEDERAL AGEN-
2 CIES.—The Commission may secure directly
3 from any Federal department or agency such
4 information as the Commission considers nec-
5 essary to carry out this section. Upon request
6 of the Chairperson of the Commission, the head
7 of such department or agency shall furnish such
8 information to the Commission.

9 (C) POSTAL SERVICES.—The Commission
10 may use the United States mails in the same
11 manner and under the same conditions as other
12 departments and agencies of the Federal Gov-
13 ernment.

14 (D) GIFTS.—The Commission may accept,
15 use, and dispose of gifts or donations of serv-
16 ices or property.

17 (2) COMPENSATION.—While serving on the
18 business of the Commission (including travel time),
19 a member of the Commission shall be entitled to
20 compensation at the per diem equivalent of the rate
21 provided for level IV of the Executive Schedule
22 under section 5315 of title 5, United States Code,
23 and while so serving away from home and the mem-
24 ber's regular place of business, a member may be al-
25 lowed travel expenses, as authorized by the chair-

1 person of the Commission. All members of the Com-
2 mission who are officers or employees of the United
3 States shall serve without compensation in addition
4 to that received for their services as officers or em-
5 ployees of the United States.

6 (3) STAFF.—

7 (A) IN GENERAL.—The Chairperson of the
8 Commission may, without regard to the civil
9 service laws and regulations, appoint and termi-
10 nate an executive director and such other addi-
11 tional personnel as may be necessary to enable
12 the Commission to perform its duties. The em-
13 ployment of an executive director shall be sub-
14 ject to confirmation by the Commission.

15 (B) STAFF COMPENSATION.—The Chair-
16 person of the Commission may fix the com-
17 pensation of the executive director and other
18 personnel without regard to chapter 51 and
19 subchapter III of chapter 53 of title 5, United
20 States Code, relating to classification of posi-
21 tions and General Schedule pay rates, except
22 that the rate of pay for the executive director
23 and other personnel may not exceed the rate
24 payable for level V of the Executive Schedule
25 under section 5316 of such title.

1 (C) DETAIL OF GOVERNMENT EMPLOY-
2 EES.—Any Federal Government employee may
3 be detailed to the Commission without reim-
4 bursement, and such detail shall be without
5 interruption or loss of civil service status or
6 privilege.

7 (D) PROCUREMENT OF TEMPORARY AND
8 INTERMITTENT SERVICES.—The Chairperson of
9 the Commission may procure temporary and
10 intermittent services under section 3109(b) of
11 title 5, United States Code, at rates for individ-
12 uals which do not exceed the daily equivalent of
13 the annual rate of basic pay prescribed for level
14 V of the Executive Schedule under section 5316
15 of such title.

16 (g) TERMINATION.—Except with respect to activities
17 in connection with the ongoing biennial report required
18 under subsection (e)(2), the Commission shall terminate
19 90 days after the date on which the Commission submits
20 the report required under subsection (e)(3).

21 (h) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated, such sums as may be
23 necessary to carry out this section for fiscal year 2004
24 and each fiscal year thereafter.

1 **SEC. 302. CONGRESSIONAL ACTION.**

2 (a) BILL INTRODUCTION.—

3 (1) IN GENERAL.—Any legislative language in-
4 cluded in the report required under section
5 301(e)(3) may be introduced as a bill by request in
6 the following manner:

7 (A) HOUSE OF REPRESENTATIVES.—In the
8 House of Representatives, by the Majority
9 Leader and the Minority Leader not later than
10 10 days after receipt of the legislative language.

11 (B) SENATE.—In the Senate, by the Ma-
12 jority Leader and the Minority Leader not later
13 than 10 days after receipt of the legislative lan-
14 guage.

15 (2) ALTERNATIVE BY ADMINISTRATION.—The
16 President may submit legislative language based on
17 the recommendations of the Commission and such
18 legislative language may be introduced in the man-
19 ner described in paragraph (1).

20 (b) COMMITTEE CONSIDERATION.—

21 (1) IN GENERAL.—Any legislative language
22 submitted pursuant to paragraph (1) or (2) of sub-
23 section (a) (in this section referred to as “imple-
24 menting legislation”) shall be referred to the appro-
25 priate committees of the House of Representatives
26 and the Senate.

1 (2) REPORTING.—

2 (A) COMMITTEE ACTION.—If, not later
3 than 150 days after the date on which the im-
4 plementing legislation is referred to a com-
5 mittee under paragraph (1), the committee has
6 reported the implementing legislation or has re-
7 ported an original bill whose subject is related
8 to reforming the health care system, or to pro-
9 viding access to affordable health care coverage
10 for Americans, the regular rules of the applica-
11 ble House of Congress shall apply to such legis-
12 lation.

13 (B) DISCHARGE FROM COMMITTEES.—

14 (i) SENATE.—

15 (I) IN GENERAL.—If the imple-
16 menting legislation or an original bill
17 described in subparagraph (A) has not
18 been reported by a committee of the
19 Senate within 180 days after the date
20 on which such legislation was referred
21 to committee under paragraph (1), it
22 shall be in order for any Senator to
23 move to discharge the committee from
24 further consideration of such imple-
25 menting legislation.

(II) SEQUENTIAL REFERRALS.—

Should a sequential referral of the implementing legislation be made, the additional committee has 30 days for consideration of implementing legislation before the discharge motion described in subclause (I) would be in order.

(III) PROCEDURE.—The motion

described in subclause (I) shall not be in order after the implementing legislation has been placed on the calendar. While the motion described in subclause (I) is pending, no other motions related to the motion described in subclause (I) shall be in order. Debate on a motion to discharge shall be limited to not more than 10 hours, equally divided and controlled by the Majority Leader and the Minority Leader, or their designees. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed or disagreed to.

1 (IV) EXCEPTION.—If imple-
2 menting language is submitted on a
3 date later than May 1 of the second
4 session of a Congress, the committee
5 shall have 90 days to consider the im-
6 plementing legislation before a motion
7 to discharge under this clause would
8 be in order.

9 (ii) HOUSE OF REPRESENTATIVES.—
10 If the implementing legislation or an origi-
11 nal bill described in subparagraph (A) has
12 not been reported out of a committee of
13 the House of Representatives within 180
14 days after the date on which such legisla-
15 tion was referred to committee under para-
16 graph (1), then on any day on which the
17 call of the calendar for motions to dis-
18 charge committees is in order, any member
19 of the House of Representatives may move
20 that the committee be discharged from
21 consideration of the implementing legisla-
22 tion, and this motion shall be considered
23 under the same terms and conditions, and
24 if adopted the House of Representatives

1 shall follow the procedure described in sub-
2 section (c)(1).

3 (c) FLOOR CONSIDERATION.—

4 (1) MOTION TO PROCEED.—If a motion to dis-
5 charge made pursuant to subsection (b)(2)(B)(i) or
6 (b)(2)(B)(ii) is adopted, then, not earlier than 5 leg-
7 islative days after the date on which the motion to
8 discharge is adopted, a motion may be made to pro-
9 ceed to the bill.

10 (2) FAILURE OF MOTION.—If the motion to dis-
11 charge made pursuant to subsection (b)(2)(B)(i) or
12 (b)(2)(B)(ii) fails, such motion may be made not
13 more than 2 additional times, but in no case more
14 frequently than within 30 days of the previous mo-
15 tion. Debate on each of such motions shall be limited
16 to 5 hours, equally divided.

17 (3) APPLICABLE RULES.—Once the Senate is
18 debating the implementing legislation the regular
19 rules of the Senate shall apply.

20 **TITLE IV—STATE WAIVERS**

21 **SEC. 401. STATE WAIVERS.**

22 (a) IN GENERAL.—Notwithstanding any other provi-
23 sion of law, a State may apply to the Secretary of Health
24 and Human Services for waivers of such provisions of law
25 as may be necessary for the State to implement policies

1 that make comprehensive, affordable health coverage
2 available for all State residents, including access to essen-
3 tial benefits with limits on cost-sharing, as provided in the
4 most recent report under section 301(e)(2).

5 (b) REQUIREMENTS.—In order to ensure that waivers
6 under this section benefit rather than harm health care
7 consumers, a State shall not be eligible for a waiver under
8 this section unless—

9 (1) the State reasonably expects to achieve a
10 level of enrollment in coverage described in sub-
11 section (a) that is at least equal to the level of cov-
12 erage (taking into account the number of insured in-
13 dividuals, covered benefits, and premium and out-of-
14 pocket costs to the consumer for such coverage) that
15 the State would have achieved if the State had fully
16 implemented the coverage options available under ti-
17 tles I and II of this Act;

18 (2) no individual who would have qualified for
19 assistance under the State medicaid program under
20 title XIX of the Social Security Act or the State
21 children's health insurance program under title XXI
22 of such Act, as of either the date of the waiver re-
23 quest or the date of enactment of this Act, will be
24 denied eligibility for such program, have a reduction
25 in benefits under such program, have reduced access

1 to geographically and linguistically appropriate care
2 or essential community providers, or be subject to
3 increased premiums or cost-sharing under the waiver
4 program under this section; and

5 (3) the State agrees to comply with such stand-
6 ards or guidelines as the Secretary of Health and
7 Human Services may require to ensure that the re-
8 quirements of paragraphs (1) and (2) are satisfied.

9 (c) FEDERAL PAYMENTS.—

10 (1) IN GENERAL.—The Secretary of Health and
11 Human Services shall pay a State with a waiver ap-
12 proved under this section an amount each quarter
13 equal to the sum of—

14 (A) the Federal payments the State and
15 residents of the State (including, but not lim-
16 ited to, through the credit allowed under section
17 36 of the Internal Revenue Code of 1986 for
18 health insurance costs) would have received if
19 the State had exercised the coverage options
20 under titles I and II of this Act with respect to
21 residents of the State who have not attained
22 age 65; and

23 (B) the amount of any grants authorized
24 by this Act that the State would have received
25 if the State had applied for such grants.

1 (2) ADDITIONAL PAYMENT FOR MEDICARE
2 BENEFICIARIES UNDER AGE 65.—

3 (A) IN GENERAL.—In the case of a State
4 that elects to enroll an individual described in
5 subparagraph (B) in coverage described in sub-
6 section (a), the amount described in paragraph
7 (1) with respect to a quarter shall be increased
8 by the amount described in subparagraph (C).

9 (B) INDIVIDUAL DESCRIBED.—An indi-
10 vidual is described in this subparagraph if the
11 individual—

12 (i) has not attained age 65;

13 (ii) is eligible for coverage under title
14 XVIII of the Social Security Act; and

15 (iii) voluntarily elects to enroll in cov-
16 erage described in subsection (a).

17 (C) AMOUNT DESCRIBED.—The amount
18 described in this subparagraph is the amount
19 equal to the amount that the Federal Govern-
20 ment would have incurred with respect to a
21 quarter for providing coverage to an individual
22 described in subparagraph (B) under title
23 XVIII of the Social Security Act (42 U.S.C.
24 1395 et seq.).

1 (d) IMPLEMENTATION DATE.—No State may submit
2 a request for a waiver under this section before October
3 1, 2007.

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